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Journal of Taibah University Medical Sciences

www.sciencedirect.com



Review Article

Medical professionalism and professional organizations

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Received 12 March 2013; revised 23 April 2013; accepted 1 May 2013

المخلص

تعرف المهنة أنها سلوكيات واتجاهات. وقد قام المجلس الأمريكي للطب الباطني بعرض 6 محاور للكفاءة المهنية الجيدة وهي: الإيثار، والمساءلة، والتميز، والواجب، والشرف، والنزاهة، واحترام الآخرين، وأدرج العناصر التالية كعناصر تنقص من كفاءة المهنة: كإساءة استخدام السلطة، والتحرش الجنسي، والصراعات على المصالح، والغطرسة المهنية، وضعف الطبيب، والغش في البحوث. ويقترح المؤلف صياغة المهنة الطبية من وجهة نظر إسلامية على المحاور السبعة التالية: الإيمان، والتقوى، والأخلاق الحسنة، واثقان العمل، والإحسان، والأمانة، ومحاسبة النفس. وبالرجوع لتاريخ الإنسان القديم كانت الممارسة الطبية تقدم من قبل غير المتخصصين، وأعضاء الأسرة، والزعماء الدينيين. إن تطور العلوم الطبية وتقنياتها تطلب تدريب الأطباء المهنيين ذو المهارات التخصصية الدقيقة معاتباع القواعد المهنية. لقد قامت المنظمات المهنية بالدفاع عن حقوق أعضائها، وتنظيم ضوابط للممارسات المهنية، وتنظيم التدريب، وتشجيع البحث العلمي والتبادل المعرفي. تدرس المهنة الطبية إما ضمن مقررات منهجية مدروسة أو من خلال اكتسابها بالاحتكاك مع القدوة أصحاب الخبرة المهنية. وهناك طرق عديدة لتقييم الكفاءة المهنية مثل استخدام مقياس "نيمغن" المهني المطور في هولندا والتقييم المهني البسيط المطور في كندا. ويمكن أيضا تقييم الكفاءة المهنية من خلال تقييم المعرفة والمواقف والممارسات المهنية، وتقييم السلوكيات الطلابية من خلال انضباطهم العملي، وتحليلهم الدقيق للحوادث الحرجة. وتخلص ورقة البحث إلى استنتاجها أن المهنة لا تزال في مرحلة التطور من ناحية التعريف والتدريس، والتقييم.

الكلمات المفتاحية: المهنة; المنظمة المهنية

Abstract

Professionalism is defined as behaviors and attitudes. The American Board of Internal Medicine (ABIM) listed 6 dimensions of good professionalism as altruism, accountability, excellence, duty, honor and integrity, and respect for others; and listed elements that erode professionalism: abuse of power and sexual harassment, conflicts of interest, professional arrogance, physician impairment, and fraud in research. The formulation of professionalism from an Islamic perspective consists of 7 dimensions: (faith (*iman*), consciousness (*taqwat*), best character (*ahsan al akhlaq*), excellent performance (*itqaan al 'amal*), strife toward perfection (*ihsan*), responsibility (*amanat*), and self-accountability (*muhasabat al nafs*). From the earliest human history medical practice was by non-professionals, members of the family and religious leaders. Development of scientific medicine and its technology required training of dedicated professionals who had specialized skills and had to follow codes of professionalism. Professional organizations were set up to defend the rights of members, regulate and discipline practitioners, regulate training, and promote scientific research and exchange. Professionalism is taught actively as structured curriculum courses or passively as apprenticeship under good role models. Various approaches are used in the assessment of professionalism such as using special instruments like the Nijmegen Professional Scale developed in the Netherlands and the Professional Mini Evaluation instrument developed in Canada. Profession-

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alism can also be assessed by (a) assessing knowledge, attitudes, and practice of professionalism; peer assessment of professionalism, (b) assessment of student behaviors such as fulfilling duties, and (c) analysis of student narratives on critical incidents.

Keywords: Professionalism; Professional organization

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Definition of professionalism

Medical professionalism is poorly conceptualized and understood; it is therefore not easy to define.¹ As a concept and practice it has its own history and has been evolving. The evolution is not at the same stage in all institutions and all countries; one place may operate with an earlier formulation of professionalism while another place may operate with a later formulation. Medical students get confused with apparently contradictory concepts of professionalism if they do not realize that they are dealing with different models of professionalism.² In general professionalism is defined as attributes and behaviors expected of a physician.³ A professional who is engaged in the same activities on a daily basis develops special skills. In earlier times with limited knowledge and technology it was possible to list skills that a professional was supposed to have; this is not possible today but the skill dimension is still assumed in attributes of professionalism such as 'excellence' because you cannot achieve excellence without being skilled.

A fair level of agreement can be reached by physicians, nurses, and the public on tangible behaviors that constitute professionalism.^{4,5} Behaviors are easier to observe and measure than are attitudes and other intangibles that are acquired by apprenticeship or experience but which cannot be described in concrete terms. It is these intangibles that can explain similar reactions of professionals to a situation without having to discuss or refer to a rule or code. The intangibles could almost be called 'trade secrets' or practical wisdom (phronesis).⁶ They can be considered under the Islamic legal principle of custom, 'urf, with various formulations such as: what is known as customary has the force of law, *al 'aadat muhakkamat* (Majallat Article No 36)⁷ and what is known customarily is considered an agreed condition among the practitioners of a profession like trade, *al ma'aruf 'urfan ka al mashroot shartan* (Majallat Article No. 43 and 44).⁸ It is easier to define professionalism negatively because the consequences of deficient professionalism are serious and are therefore very prominent as professional malpractice and negligence.

The definition of professionalism varies by place, time, and culture.⁹ While a panel of Arab medical professionals and academics found the 6 dimensions of the formulation of professionalism by ABIM appropriate to the Arab context, they added autonomy to make 7 dimensions.¹⁰ A US study found little difference between native and immigrant medical students in perceptions of professionalism but differences were found between graduates of Indian and North American schools.¹¹ A Taiwan formulation found differences from the western one with special emphasis on the centrality of self-integrity and harmonization between personal and professional roles.¹²

Most existing definitions of professionalism were formulated from a European perspective that is based on secular, Greco-Roman, and Judeo-Christian world views. This perspective is found in all parts of the world where Europeans settled (Americas, Australia, New Zealand, and South Africa) or where they dominate the intellectual and professional scene. Because of its different world view, the Muslim world is also challenged to formulate a definition of professionalism that could differ from the European one. In this paper I shall use the formulation of professionalism by ABIM as a prototype of the European formulation and then present what I think should be the Muslim formulation.

The ABIM formulation of professionalism is a fair representation of the thinking in Europe and America. It listed 6 dimensions of good professionalism (altruism, accountability, excellence, duty, honor and integrity, and respect for others) and also listed 5 attitudes, behaviors, and actions that erode professionalism (abuse of power and sexual harassment, conflicts of interest, professional arrogance, physician impairment, and fraud in research).¹³ The ABIM formulation is very practical and pragmatic by having both positive and negative definitions that leave little room for ambiguity. It has some defects: it is not exhaustive enough and has no statement of an underlying moral theory that could be the basis for the intangibles of professionalism which as mentioned above exist but are not obvious. The formulation below from a Muslim perspective attempts to overcome these defects.

Professionalism from an Islamic perspective should be based on basic values that consist of faith (*iman*), consciousness (*taqwat*), best character (*ahsan al akhlaq*), excellent performance (*itqan al 'amal*), strife toward perfection (*ihsan*), responsibility (*amanat*), and self-accountability (*muhasabat al nafs*). *Iman* improves professionalism in two ways: (a) motivating the practice of holistic medicine emanating from the integrative doctrine of *tauihd* (b) making the physician more humble and less arrogant through the realization that he is an agent and not the cause of cure; cure is in Allah's pre-determination, *qadar*. *Taqwat* makes the physician conscious of his duties and meticulous in performance in the full knowledge that Allah is watching and knows all what is being done unlike human observers who cannot see hidden mistakes and bad intentions. *Akhlaq* ensure the best human interaction between the physician on one hand and the patients and professional colleagues on the other hand manifesting as balance (*tawazun*), humility (*tawadh'u*), brotherhood (*ukhuwwat*), social respectability (*muru'at*), *Itqan* and *ihsan* motivate the physician to improve his skills and knowledge to have the best outcome in his medical procedures. The physician should take his work as a trust (*amanat*), involving: sincerity of intentions (*ikhlas al niyyat*); quality work (*itqan & ihsan*), and social responsibility. As one author observed professionalism is part

Table 1: Proposed Islamic formulation of the basic values of professionalism.

Faith (<i>iman</i>)
Consciousness (<i>taqwat</i>)
Best character (<i>ahsan al akhlaq</i>)
Excellent performance (<i>itqaan al 'amal</i>)
Strife toward perfection (<i>ihsan</i>)
Responsibility (<i>amanat</i>)
Self-accountability (<i>muhasabat al nafs</i>)

of the social contract involving responsibility of the professional to society.¹⁴ The physician will accept accountability (*muhasabat*) for any defects in the work and will be ready to make corrections and amends (see Table 1).

Brief history of professionalism

Professionalism has grown *pari passu* with the development of medical knowledge and medical technology. The earliest medical professionals doubled as religious leaders because religion and medicine were inseparable. In Pre-historic times magic and superstition were mixed with medical care and were closely related to the prevailing belief systems. Mesopotamian medicine was magico-religious with priests serving also as physicians. Early Egyptian medicine was mystical and priestly. Chinese, Indian, Roman, and Greek medicine were related to religions and beliefs and religious leaders played leading roles. European medicine of the Middle Ages was closely related to religious beliefs and the Christian priests had leading roles. In my understanding Muslim medicine was the first to have physicians who did not have a religious vocation and in reality many of the leading physicians in the Abassid era, the golden era of Muslim medicine, were not Muslims. Professionalism was taken seriously in the Abassid era with physicians having to pass a rigorous examination before being allowed to practice.

Modern European medicine was stimulated by the transfer through translations of Muslim medicine from the Near East and North Africa through Spain and Italy to the rest of Europe. The empirical approaches of Muslim medicine stimulated the growth of medical science and technology starting in the renaissance and culminating in the great discoveries of the late 19th and early 20th centuries of the Gregorian calendar. Before the era of scientific medicine the medical profession was in general practiced by untrained people in the home and outside the home. Professionalism started when scientific medicine required specific professional training with medical schools being set up in Baghdad and Cairo and later in various European cities. The professional standards required increased with growth of medical knowledge and technology with the emphasis being practical skills and knowledge.

Medical professional organizations starting in the 19th century were essentially 'trade unions' with the objective of protecting and promoting the interests of the members. The first task they addressed was to improve the knowledge and skills of professionals to gain public respect for example a medical and surgical journal founded in Philadelphia in 1826 had the objective of changing the poor public opinion of the medical profession.¹⁵ After gaining respect for the profession by improving standards of training and practice, the professional

bodies turned to their main mission of protecting the interests of their members that sometimes involved forays into controversial political advocacy¹⁶ and they can run into conflicts of interest especially if they accept money from commercial organizations.¹⁷

By the end of the 20th century professionalism changed to fit the changing medical scene.¹⁸ Professionalism became formal codes of professionalism¹⁹ that physicians were required to follow although full compliance was not always guaranteed.²⁰ The human dimension of professionalism that was known before the technology era found renewed emphasis with patient-physician relation came to the fore. The pressures of managed medicine resulted in situations in which physicians were no longer independent professionals with the last word on how to treat their patients but have to consider managerial wishes regarding resources.²¹ The increasing democratization of society and the assertion of patient rights forced a change from a paternalistic model of practice under which the physician was assumed to know what was in the patient's best interests to the autonomy model that envisages a role for the patient in medical decision making and control of treatment. Medical e-professionalism and tele-medicine were another challenge than changed medical professionalism by eliminating the direct physician-patient interaction.²²

Brief history of professional organizations

Several types of professional organizations can be described according to objectives: defense and promotion of professional interests of physicians, defining and enforcing professional standards in medical training and practice, promoting academic research and exchange, and outreach to the community. I shall describe representative examples of each type of organization.

Modern medical professional organizations arose in the 19th century of the Gregorian calendar in Europe and America with the primary objective of advocating for the interests of their members. They had the additional role of establishing and enforcing professional codes²³ but this role has been shared with governmental or semi-governmental organizations. Among the earliest professional organizations set up to defend and promote doctors' rights were the British Medical Association (BMA) in the UK, the American Medical Association (AMA) in the US, and the Canadian Medical Association (CMA) in Canada. The forerunner of BMA was formed in 1832 as a trade union for doctors in Britain and got its present name in 1856. It publishes the British Medical Journal and runs various educational programs for its members.²⁴ AMA was established in 1847, represents the majority of US doctors, and publishes the Journal of the American Medical Association (JAMA). Its main work is its advocacy for its members: lobbying for favorable legislation at federal and state levels, defending private medical care, limiting damages for malpractice.²⁵ CMA is the largest physician organization in Canada set up in 1867. It fights for physician interests and runs a pension fund for them.²⁶

Professional organizations that regulate the registration and disciplining of physicians exist in all countries and are governmental or semi-governmental. Among the earliest was the General Medical Council in the UK set up by Parliament in

1856. It sets standards for registering doctors. It maintains professional standards, disciplines physicians, and regulates standards of under graduate and post graduate education.²⁷ The role of GMC in the US is undertaken by statutory bodies at the state level. In Saudi Arabia this role is undertaken by the Saudi Commission for Health Specialties established by Royal Decree No. M/2 on 6/2/1413 AH to undertake several roles: registration and training of health professionals.²⁸

Postgraduate medical education in the UK, US, Canada, Australia, and New Zealand is controlled by private non-governmental colleges, one for each specialty. Some of the colleges were set up a long time ago for example the Royal College of Physicians of London was set up in 1518 and The Royal College of Surgeons of Edinburgh was set up in 1505. Doctors who complete postgraduate training are admitted to membership of a royal college (in the UK, Canada, Australia, and New Zealand) and to the American Board in each specialty.

Each academic medical discipline set up a professional academic association that publishes a journal and holds seminars and conferences. The number of associations is increasing daily as growth of knowledge leads to more sub-specialty specialization requiring an association for each sub specialty or sub-sub specialty. These organizations focus on research and academic exchange among members. They also play a role in fostering networking among members. Academic associations can join regional and international federations.

Some professional organizations are set up on the basis of faith such as the Christian Medical Associations²⁹ and the Jewish Medical Association.³⁰ The Islamic medical associations (IMAs) have played many roles in disaster relief, medical assistance, famine relief, and other humanitarian programs. The first IMA was set up in the US and Canada in 1975.³¹ It was followed by IMAs in Jordan, Malaysia, Egypt, Pakistan, South Africa, Uganda, and others. They united to form the Federation of Islamic Medical Associations (FIMA) in 1981.³² IMAs are also interested in the Islamic perspective of medicine.

Teaching professionalism

Growing awareness of the importance of professionalism and the horrors of the consequences of its failures have forced including professionalism in medical curricula at undergraduate and postgraduate levels.³³ Schools struggled to introduce a culture of professionalism using various strategies³⁴ including integration of ethics and humanities.³⁵ The teaching should be as early as possible in the medical course before students pick up bad habits. Professionalism in Ireland was taught as an interdisciplinary course assessed by a student essay³⁶ and in California as part of an integrated longitudinal program starting early in the medical course.³⁷ Among teaching methods used were: use of simulated emails,³⁸ using movies,³⁹ medical television programs portraying hospital practice,⁴⁰ discourses on professionalism,⁴¹ online programs,⁴² and learning from malpractice suits and malpractice experiences.⁴³

Teaching of professionalism can be passive as apprenticeship. Apprenticeship remains the best method because it is one to one and teaches practical wisdom⁴⁴ and students learn from good role models.⁴⁵ The disadvantage of apprenticeship is that students may feel deficient in professionalism if they do not get teachers who are good role models.⁴⁶

Assessing professionalism

Due to its central role in medical practice, professionalism has been assessed among students and among physicians in practice. Student assessment can be at the start, during, and at the end of the medical course.⁴⁷ Assessment at the start is useful to detect and start correcting unprofessional behaviors and attitudes. Assessment enables us assess whether what students know is what the teachers taught.⁴⁸ Professional attitudes are set quite early in the student's career by the 'hidden curriculum'. Early assessment enables discoveries of unprofessional attitudes and behaviors quite early. Exposure to unprofessional behavior was least in the first year and highest in the fifth year.⁴⁹ Unprofessional behavior in student days is likely to resurface during internship⁵⁰ and professional practice.⁵¹ Students with low professionalism are more prone to errors.⁵²

Various approaches are used in assessment. Special instruments have been developed such as the Nijmegen Professional Scale developed in the Netherlands⁵³ and the Professional Mini Evaluation instrument developed in Canada.⁵⁴ Other approaches used are: assessing knowledge, attitudes, and practice of professionalism⁴⁷; peer assessment of professionalism,⁵⁵ assessment of student behaviors such as fulfilling duties,⁵⁶ and analysis of student narratives on critical incidents.⁵⁷

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